NURSING HOME INCOME QUESTIONNAIRE

INCOME QUESTIONNAIRE FOR 36 MONTHS: **FROM 2012 TO 2014**

NAME & LOCATION OF PROPERTY **OWNER AND ADDRESS OF RECORD**

GROSS FLOOR AREA _____
TOTAL # OF ROOMS_____
TOTAL # OF PRIVATE BEDS _____
TOTAL # OF SEMI-PRIVATE BEDS _____
TOTAL # OF SUBSIDIZED BEDS_____
TOTAL # OF BEDS _____
ANNUAL OCCUPANCY RATE _____

BED RATES:

PRIVATE PAY: 1. PRIVATE ROOM RATE _____
2. SEMI-PRIVATE ROOM _____
GOVERNMENT SUBSIDIZED ROOM RATE _____
SERVICES PROVIDED IN DAILY RATE_____
(ATTACH LIST & EXPLAIN)_____
_____
_____

	2014	2013	2012
REVENUE:			
1. ROOM & BOARD			
2. MEDICAL & NONMEDICAL ANCILLARY SERVICES			
3. OTHER INCOME			
4. LOSS DUE TO BAD DEBT			
5. EFFECTIVE GROSS INCOME			
OPERATING EXPENSES:			
1. ADMINISTRATION			
2. MANAGEMENT FEE			
3. DIETARY			
4. LAUNDRY & LINEN			
5. HOUSEKEEPING			
6. PLANT OPERATIONS			
7. SOCIAL SERVICES & ACTIVITIES			
8. OTHER PATIENT CARE			
9. NURSING			
10. ANCILLARY			
11. NON-REIMBURSABLE			
12. MISCELLANEOUS			
13. INSURANCE			
14. RESERVES FOR REPLACEMENT			
15. OTHER (LIST)			
16. TOTAL OPERATING EXPENSES			
NET OPERATING INCOME			
CAPITAL EXPENSES:			
1) FURNITURE FIXTURES & EQUIPMENT			
2) REAL ESTATE TAXES			
3) MORTGAGE PAYMENT			
4) BUILDING DEPRECIATION			
5) CAPITAL IMPROVEMENTS			

MORTGAGE/SALES INFORMATION:

1. Is there a current mortgage on this property? **Yes** _____ **No** _____

2. If Yes, please provide the following data:

_____	_____	_____
Name of Mortgagee	**Mortgage Amount**	**Interest Rate**
_____	_____	_____
Term of Mortgage	**Date 1st Payment**	**Monthly Payment**

3. Please provide: **Date Purchased**_____ **Consideration**_____

I declare, under the penalties of perjury, that the contents of this form and all the accompanying schedules and statements have been examined by me and are true, correct, and complete to the best of my knowledge, information, and belief.

_____	_____	_____
Signature	**Title of Signer**	**Date**
_____	_____	
Print/Type Name of Signer	**Phone Number**	**RP-68 (Rev. 12/03rs)**